studies are for preventive measures on behalf of apparently well, asymptomatic persons at low medical risk. They are not intended for those persons at increased risk of a condition or who have symptoms. There remains a great deal to be learned about the efficacy of periodic health examinations. Well-designed studies to assess the usefulness of health screening procedures still remain to be done. Accepting that many of these recommendations are based on incomplete data, primary care practitioners should select a periodic screening measure consistent with their interpretation of available information and incorporate it into a specific plan of preventive care for each patient.

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Acquired Immune Deficiency Syndrome (AIDS)

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) is the term currently applied to an expanding epidemic of severe immunosuppression first recognized as an increased occurrence of Kaposi's sarcoma and *Pneumocystis carinii* pneumonia among previously healthy persons. Between June 1, 1981, and February 10, 1983, the Centers for Disease Control (CDC) received reports of 1,051 cases of acquired immune deficiency syndrome (that is, Kaposi's sarcoma or serious opportunistic infections) with fatality in 41 percent overall and in greater than 60 percent in those diagnosed more than a year ago. Although 80 percent of the reported cases were concentrated in six cities, predominantly on the East and West Coasts, well-documented cases have occurred in more than 33 states and 13 foreign countries. The reported incidence continues to rise rapidly.

Populations considered to be at risk include homosexual or bisexual men (75 percent of cases), heterosexual male and female intravenous drug abusers (13 percent), heterosexual Haitians with no history of intravenous drug abuse (6 percent) and persons with hemophilia A (three cases). Although the CDC's definition of acquired immune deficiency syndrome requires the unexplained occurrence of Kaposi's sarcoma, *P carinii* pneumonia or infections associated with defective cell-mediated immunity, the full spectrum of the syndrome may include asymptomatic abnormality of lymphocytes now reported in gay men and nonspecific constitutional symptoms with or without generalized lymphadenopathy. The prevalence of other malignant disorders (diffuse undifferentiated non-Hodgkin's lymphoma, squamous carcinoma of the anorectum and of the oral cavity) and autoimmune thrombocytopenia also appears to be increased in gay men.

The pathogenesis of acquired immune deficiency syndrome is unknown. Epidemiologic evidence is most consistent with the presence of an agent or agents transmissible by blood. Two immunosuppressive and oncogenic herpesviruses, cytomegalovirus and Epstein-Barr virus, are candidate agents, but genetic (HLA-DR5) factors and amyl nitrite exposure have also been implicated.

There is no laboratory screening test for acquired immune deficiency syndrome. Immunologic abnormalities in established cases have included lymphopenia, cutaneous anergy and alterations in T-lymphocyte subsets as measured by monoclonal antibodies to markers for suppressor and helper function. However, delayed cutaneous hypersensitivity and quantitatively normal lymphocyte counts do not exclude a significant defect in immunoregulation and abnormalities in T-cell subsets are not yet established as predictive of the development of this disorder.

Physicians should be familiar with the features of this syndrome and keep patients in identified risk groups under surveillance. Gay men who wish to reduce their risk should reduce the number of sexual partners.

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